Mental Welfare Commission for Scotland

Report on announced visit to: Fyvie Ward, Royal Cornhill Hospital, Cornhill Road, Aberdeen, AB25 2ZH

Date of visit: 3 November 2020

Where we visited

Due to the Covid-19 pandemic, the Commission postponed all scheduled local visits in March 2020. From August 2020 the Commission is undertaking a phased return to our visit programme following recommendations in the Scottish Government's route map to recovery.

This visit took place during Phase 3 the Scottish Government's route map to recovery and at a time of additional restrictions to patients due to the Covid-19 pandemic. Since the end of March 2020, the hospital has made major changes to the usual model of care in an attempt to contain Covid-19 transmission on site. This model of care has been more restrictive but closely monitored. Although restrictions remain in place in the ward, we heard that most patients have generally coped well with the experience of the ongoing pandemic.

This visit was to Fyvie Ward, which is a 20-bedded functional assessment older adult ward set within the Royal Cornhill Hospital. The ward has temporarily moved from Muick ward during a major refurbishment as part of the anti-ligature improvement programme. The ward, though recently refurbished, lacked the normal signage and decorative features as the intention is for the environment to be preserved for future use by another service once the current ward returns to Muick. The ward beds were fully occupied at the time of this visit. We also noted that one older adult dementia assessment ward and day hospital had closed during the pandemic to improve the staffing in the remaining wards.

We last visited this service on 21 May 2018 and made a recommendation in relation to the mix of patients on the ward.

On the day of this visit we wanted to meet with patients and follow up on the previous recommendation that patients with functional mental illness are given priority over patients with other conditions e.g. dementia or younger adults in referrals to the ward . We also wanted to find out how the ward has been managing in relation to the current Covid-19 pandemic and what impact this has had on patients within their care and treatment and to friends, family and carers.

Who we met with

We met with and/or reviewed the care and treatment of eight patients.

We spoke with the senior charge nurse (SCN), nursing staff, and health care support workers.

Commission visitors

Ian Cairns Social Work Officer

Douglas Seath, Nursing Officer

What people told us and what we found

Care, treatment, support and participation

We met with a number of patients who told us that they were happy on the ward, and they appeared settled and relaxed in the environment. We observed supportive interactions between nursing staff and patients in the ward during our visit.

We saw detailed nursing assessment documentation in patient files which gave a good account of the patient's background and current circumstances. There were also rapid risk assessments followed by more detailed management plans and these were clear and easy to find. We also found evidence that one-to-one meetings with nursing staff (as per care plans) were being carried out. Although these were generally recorded, clearer highlighting of these interactions would be beneficial.

There was clear evidence of assessment of mental health needs and a detailed emphasis on physical healthcare with associated screening tools covering a range of physical health care needs.

The ward has a full time occupational therapist (OT), OT assistants and a referral system is in place should a patient require assessment and/or treatment from another allied health professional (AHP), However, the sheet to record such referrals was blank in all files. There is daily input from physiotherapy and most of the files contained a psychology assessment with some patients also receiving ongoing input.

Managers told us that the multidisciplinary team (MDT) meetings are held weekly with the range of professionals involved in the patient's care attends including pharmacy. We saw detailed minutes of MDT meetings in the patient files with clear actions and outcomes being recorded.

We saw care plans that were detailed, holistic and regularly reviewed; the care plans were person-centred, and while some individual plans could have had more detail there was generally appropriate information about specific nursing interventions and plans. Plans also showed a strong focus on maintaining and developing living skills, and promoting independence. This has been impacted on to a degree by the Covid -19 pandemic, in terms of patients spending time off the ward. However, there was a commitment to maintaining activities as far as possible.

We considered that further improvement could be made with earlier introduction of active care plans. We found that the use of assessment care plans, well into the patients' stay, did not provide detail of the nursing interventions that were clearly taking place. Once the needs assessments have been completed, a clear care plan with goals and expected outcomes should be compiled, indicating active interventions that are taking place with the involvement of the patient.

The Commission has published a good practice guide on care plans. It is designed to help nurses and other clinical staff create person-centred care plans for people with mental ill health, dementia or learning disability, and can be found at:

https://www.mwcscot.org.uk/sites/default/files/2019-08/PersonCentredCarePlans_GoodPracticeGuide_August2019_0.pdf

Recommendation 1:

Managers should ensure that the initial assessment in care plans are replaced at the earliest opportunity. Person-centred interventions that meet the identified needs should be outlined and recorded in patient care plans.

Use of mental health and incapacity legislation

On the day of our visit paperwork under the Mental Health Act (Care and Treatment) (Scotland) 2003 ('the Mental Health Act') was easy to access within patients' records.

Part 16 (s235-248) of the Mental Health Act sets out the conditions under which treatment may be given to detained patients, who are either capable or incapable of consenting to specific treatments. The authorising treatment forms (T3) were in order, and a copy of the form kept beside the drug prescription sheet. One prescription for an informal patient included 'as required' medication by intramuscular injection. The medication had never been administered and staff agreed to have it removed.

For individuals who had an appointed legal proxy in place under the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act') we saw a copy of the document in the patient's file.

We were pleased to see that AWI Act Section 47 certificates had detailed information about actual treatment interventions with the treatment plan attached to the certificate for ease of reference. Detailed treatment plans will be increasingly important during the pandemic in terms of patients' capacity to consent.

Rights and restrictions

There is a secure entry to the ward accessed by a doorbell entry system. There is a locked door policy in place and was on display. We discussed this with staff and gave advice on how to ensure patients' rights are respected when they have been admitted on a voluntary basis. The locked door also enabled nursing staff to ensure that all visitors adhere to the measures to prevent spread of infection, e.g. hand hygiene and use of face masks.

The Commission has developed *Rights in Mind.* This pathway is designed to help staff in mental health services ensure that Patients have their human rights respected at key points in their treatment. This can be found at:
https://www.mwcscot.org.uk/law-and-rights/rights-mind

Activity and occupation

Activities were provided by OT staff with input from nursing staff. There was a timetable of activities displayed on the ward and patients had their own timetable and were able to access activities within the ward. These included music, quizzes, exercise, and knitting and tended to be one-to-one due to current restrictions.

The staff record patient activities with details of each patient's interests, likes and dislikes. We saw daily recordings of activities occurring and how the activity benefitted the patient.

Although visiting is restricted at present, patients were able to contact relatives via video link on a daily basis.

The physical environment

The ward is situated on the first floor of the building. However, the design of the building allows for access to the outdoor garden and walks in the hospital grounds.

The bedrooms are a mixture of large dormitories and en-suite single rooms. There is a separate dining/sitting room on the ward but we found that there is a lack of quiet seating areas for patients to use. The ward was clearly not designed specifically for the patient group and the lack of a bath was highlighted as a significant issue. We were informed that a bath will be included in the design for the refurbishment when the patients return to Muick Ward in future. There was also a shortage of visiting space offset to a degree by the reduced level of visiting during the pandemic.

On occasions where it was required to provide stress and distress interventions, the compact design of the ward made it difficult to observe patients who needed this level of input in a separate area. This will be resolved within the larger area and better design of the original ward should patients with dementia continue to be admitted.

Any other comments

During the previous visit, we observed that there was an inappropriate mix of patients admitted for: assessment of functional illness; assessment of dementia; and those individuals with adult acute mental health needs in the ward. On this visit, patients had been mainly admitted for assessment of functional illness with some assessed as having early stage dementia.

We were advised of the situation where, on occasions patients with dementia are admitted to assessment beds; the needs of this group have an impact on other admissions. We are aware there is a review of services for older people with mental health problems in Grampian underway at present, and will be interested to hear the outcome of this review in due course.

Recommendation 2:

Managers should ensure that the needs of patients with functional mental illness are prioritised over those with other conditions e.g. dementia with future referrals to the ward

Summary of recommendations

1. Managers should ensure that the initial assessment in care plans are replaced at the earliest opportunity. Person-centred interventions that meet the identified needs should be outlined and recorded in patient care plans.

2. Managers should ensure that the needs of patients with functional mental illness are prioritised over patients with other conditions e.g. dementia with future referrals to the ward.

Service response to recommendations

The Commission requires a response to these recommendations within three months of the date of this report.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

CLAIRE LAMZA
Interim Executive Director (Nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.
The Commission visits people in a variety of settings.

The MWC is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards

When we visit:

- We find out whether individual care, treatment and support is in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice and guidance to people we meet with.

Where we visit a group of people in a hospital, care home or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.
Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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